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MBS Review Ophthalmology and Psychiatry Reports (and acknowledgement of other reports)

AMA submission to the MBS Review Taskforce

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Introduction
As always, the Australian Medical Association (AMA) welcomes the opportunity to provide responses to the draft MBS Review clinical committee reports. The AMA has always stated its support for a review of the MBS, provided it is transparent, clinician-led, not a cost-saving exercise and has a strong focus on supporting quality patient care.

As stated in previous submissions to the MBS Review Taskforce, the AMA generally refers to the relevant colleges, associations and societies (CAS) for their clinical expertise and advice on the report findings and recommendations at this level of detail. The AMA will generally provide feedback on the broader strategic and policy aspects that have been commonly raised by the CAS groups or our members.

Accordingly, the AMA does not have any specific comments on the Otolaryngology, Head and Neck Surgery, Cleft Dental Services and Paediatric Surgery Clinical Committee reports. The AMA urges the MBS Review Taskforce and clinical committees to consider the specific clinical feedback the relevant CAS groups provide on the review recommendations, as they are best placed to respond in detail and provide clinical evidence and best practice options.

The AMA, however, provides specific feedback below, on the draft MBS Review Taskforce Ophthalmology and Psychiatry clinical committee reports.

Ophthalmology Clinical Committee report
The AMA notes with great interest, the important feedback, from the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). The AMA understands that RANZCO supports the majority of recommendations 1 to 17 of the draft report, however, with caveats and suggested amendments. The AMA trusts that the Taskforce will consider the clinical advice and feedback received from RANZCO and other relevant craft groups.

With regard to recommendations 18 and 19 of the report, from the broader strategic and policy viewpoint, the AMA shares RANZCO's concerns and also do not support these recommendations. These concerns are discussed in detail below.

Recommendations 18 - reduced rebates for intravitreal (IVI) injection items 42738, 42739 and 42740

The AMA does not support the proposed reduction of the MBS fees by almost 70 per cent, for the three IVI injection MBS items, from $305.55 to $95.10. The AMA is informed that in Australia, intravitreal injections (IVI) are administered by ophthalmologists and the vast majority use anti-vascular endothelial growth factor (anti-VEGF) medications for the treatment of neovascular age-related macular degeneration (nAMD) and other chronic conditions of the eye.[1]

nAMD is the most common macular disease for older Australians and Australia's leading cause of severe vision loss and blindness.[1] Given the burden of eye disease and the current service provision setting of IVI injections (82 per cent of which are estimated to be provided privately), [1] this recommendation is a significant disinvestment in services with great risks of unintended consequences. These risks may include, creating unviable services, particularly in rural areas, where treatment options may become unavailable; increased out of pocket costs; and risk of patients delaying or not seeking treatment as there are limited publicly available service options.

The AMA has consistently called for the Review to be clinician led, not least, to ensure clinicians have some ownership and level of acceptability of the proposed changes, and they possess the deep craft speciality knowledge required to consider all the potential consequences, including those unintended, in any change. Therefore, Recommendation 18 proposed by the MBS Review Taskforce and not endorsed by the Chair of the Clinical Committee, is of concern to the appropriateness of the process.

Recommendation 19 - to assess the expansion of intravitreal injections to include appropriately trained nurse practitioners and optometrists.

The AMA has significant concerns about providing access to MBS items currently only accessible by medical practitioners to non-medically qualified providers, as this may risk patient safety and reduce comprehensive and holistic medical eye care. Ophthalmologists attend many years and ongoing hours of medical specialisation to effectively and safely provide comprehensive diagnosis, treatment and ongoing management of eye pathologies and diseases. Nurse practitioners and optometrists are valuable members of the ophthalmology care team, however, are not medically trained to provide comprehensive medical eye care, which intravitreal injections are but one component of an ophthalmology service, and should not be undertaken without regard to the whole patient's eye care needs.

The AMA also does not believe that the expansion of intravitreal injections to include appropriately trained nurse practitioners and optometrists is the best way to address broader ophthalmology supply issues of total undersupply and workforce maldistribution.

[1] Impact of IVI rebate changes final report, PWC on behalf of RANZCO, unpublished October 2019

The AMA believes that these issues are outside the scope of the role of the MBS Review Taskforce. The significant issue of ophthalmology supply, instead, should be clearly defined and advice sought from a broad range of ophthalmology workforce and training experts and clinical representatives, to develop a comprehensive and coordinated solution that has a holistic focus, centred on the patient and clinically appropriate care pathways.

Furthermore, as discussed in the AMA's response to the MBS Review Report from the Nurse Practitioner Reference Group, and reiterated again here, the MBS is not the process for expanding scopes of practice. The AMA's view is that any action by a non-medical practitioner profession to expand its scope of practice must occur within the auspices and national governance framework of Health Ministers and the Australian Health Practitioners Regulation Agency. This process ensures that:

- there are no new safety risks for patients;
- the change to scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking into account supervision costs.

The processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies; and
- there are documented protocols for collaboration with other health practitioners.

Any expansion of MBS items for nurse practitioners and optometrists should only be considered after the above process has been undertaken, not before. Advocating for an expansion of MBS items for intravitreal injections to include nurse practitioners and optometrists is not an appropriate way to design the health care system to meet the current and future needs of the community.

Furthermore, this recommendation is inconsistent with other MBS Review Clinical Committee recommendations whereby new services are not considered through the MBS Review process, and instead, are often required to be assessed via the Medical Services Advisory Committee (MSAC) process.

Psychiatry Clinical Committee report

The AMA notes that the Committee reviewed 53 psychiatry MBS items (including 52 consultation and attendance items and one procedural item) and recommended changes to 11 items. The AMA provides the following feedback on Recommendations 2 and 11 of the report.

Recommendation 2 - Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients

The AMA does not support this recommendation to replace item 288 (which provides a 50% loading for video conference consultations) with a new suite of time-tiered items for telehealth consultations provided to patients in regional and remote areas.

It is recommended that the new items would remunerate at the same rate as standard consultation items (300–308), except for initial consultations, where two time-tier items will be provided that mirror the standard initial consultations items 296 and 297. This recommendation will effectively remove the financial incentive to provide psychiatric services to patients in regional and remote areas and remove the remuneration that provides for the additional complexities of delivering telehealth consultation services to these locations (acknowledged in the Committee report to exist).

The Committee report also acknowledges that the deletion of item 288 could lead to a decrease in telehealth services or significantly alter service delivery. This concern has certainly been strongly expressed by AMA psychiatry members who currently provide psychiatry telehealth services to patients in regional and rural areas. Members that provide a large volume of these services have advised that their services will be made economically unviable and that many of these services will cease if this recommendation is implemented or a similar financial incentive is not instated. This recommendation is not in the interest of patients and goes against the principles of the MBS Review Consumer Panel report, therefore cannot be supported.

Recommendation 10 - Aligning items 855 to 866 with best practice - case conferencing

The Committee recommends aligning psychiatry-specific case conferencing items with the changes proposed in the Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC) report. This includes a new case conference framework, new items to remunerate allied health professionals to participate in case conferences and mandatory requirements for participation or invitation of GP or patient (or delegate).

The AMA provided a detailed response to the case conferencing recommendations in the SCPCCC report (available here) and summarised as follows:

- The AMA does not oppose the new framework for case conferences as it aligns with the AMA's position regarding the centrality of General Practice and patient-centred care.
- The AMA supports patients having the opportunity to be involved in a multi-disciplinary case conference. However, patients who are unable to participate in their care planning, due to their clinical condition, must be acknowledged and guidance on how to proceed provided in their absence.
- The practicalities of the proposed item descriptor that require GPs and patients to be invited to attend community and discharge case conferences require further discussion. Having to coordinate separate meetings that align the availability of busy GPs, and patients, would be logistically and administratively complex.

- The AMA requests clarification on the requirements to substantiate the claiming of the proposed new case conference items.
- The AMA has no objection to AHPRA registered allied health professionals privately practicing and who are a member of the patient's health care team being granted access to a rebate for participation in multi-disciplinary case conferencing. The AMA is concerned however, with the impractical proposed new explanatory note (as per Recommendation 9 of the General Practice and Primary Care Clinical Committee (GPCCC): Phase 2 report) that requires each provider participating in case conference to seek the permission of the patient. This requirement should only be the responsibility of the coordinating practitioner.

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